

**Utah Defined Contribution Risk Adjuster
Plan of Operation**

As of October 26, 2010

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Utah Defined Contribution Risk Adjuster Board (as of October 26, 2010)

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Section 1 - Introduction to Defined Contribution Market

Defined contribution health benefit plans are employer-sponsored health plans that allow individual employees control over their plan choice. In a defined contribution arrangement, the employer offers a pre-determined level of funding for the employees to use to purchase their choice of health insurance, rather than providing a certain level of health benefit.

A defined contribution approach to health insurance puts consumers in control of their health benefit choice while preserving all of the federal tax advantages currently available through an employer-sponsored arrangement. Having consumers more engaged in the process may lead to more efficient health care choices and better health.

For the employer, requirements and decisions are simplified. Their primary decision is how much to contribute toward the employee's health benefit each year. The ability to make a defined contribution to employees' preferred plans allows employers to more easily plan for future health benefit costs.

Employees, not employers, choose the health care coverage from the options available using the pre-tax employer contributions and pre-tax personal funds. Workers who currently do not qualify for employee health coverage may become eligible to receive an employer contribution toward their health insurance. In addition, health benefits are portable from job to job if both employers participate in the Health Insurance Exchange ("Exchange") defined contribution arrangements.

Section 2 - Utah Defined Contribution Risk Adjuster Board

The responsibility of the Utah Defined Contribution Risk Adjuster Board (“Board”) is to create a Plan of Operation to implement the provisions of the Defined Contribution Risk Adjuster Act.¹ The Board is made up of:

- Several directors with actuarial experience who represent insurance carriers participating in the defined contribution market;
- One director representing an employer participating in the defined contribution market;
- One director who represents the Office of Consumer Health Services;
- One director with actuarial experience representing the Public Employees Health Plan; and
- One director who is the Utah Insurance Commissioner or a representative appointed by the Utah Insurance Commissioner, with actuarial experience.

The Board will meet as often as necessary to effectuate the provisions of the Risk Adjuster Act and to develop and implement the plan of operation. The board usually meets on the 4th Tuesday of each month at 1 p.m. at the Utah Insurance Department Conference Room (Room 3112 of the State Office Building). As needed, the chair may adjust the time, date, or place.

At his/her discretion and with the consent of three additional directors, the Chair may call special meetings if needed.

The Board has enacted Articles of Organization and Bylaws, which are attached as Appendices A and B and incorporated herein by this reference.

All Board Meetings will comply with the Utah Open Meetings Act.² Notice of Board meetings and Minutes of Board meetings, as well as other related materials, will be posted on the Utah Insurance Department’s website. The URL for the Department’s website is www.insurance.utah.gov. For the Utah Public Meeting Notice, please refer to www.utah.gov/pmn.

By resolution of the Board of Directors, the Board may hold meeting by electronic means. See Appendix C, “Resolution to Permit Electronic Meetings, Utah Defined Contribution Risk Adjuster Board”, which is incorporated herein by this reference.

¹ Utah Code Annotated, Title 31A, Chapter 42

² Utah Code Annotated, Title 52, Chapter 4.

Section 3 - Risk Adjuster Board's Goals & Guidelines

The following guidelines were adopted by the Board to provide ongoing guidance in implementing the risk adjustment mechanism and premium allocation process. These goals and guidelines are not intended to supersede or supplant any part of the Defined Contribution Risk Adjuster Act.

Whenever any particular course of action is considered, it should be tested against these goals and guidelines prior to adoption. A course of action that fails to support and further any of these goals and guidelines should not be adopted.

- Utilize principle-based policies and procedures
- Align incentives for all stakeholders
- Risk normalization, not financial equalization, between participating insurers
- Promote long-term financial viability through appropriate risk mechanisms and avoid becoming a risk “dumping ground”
- Promote choice and consumer responsibility
- Promote transparency
- Simplify wherever possible

Section 4 - Employer Eligibility and Responsibilities

Eligibility

Small Employers

As defined in Utah Code Annotated³, a "small employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

- (a) employed an average of at least two employees but not more than 50 eligible employees on each business day during the preceding calendar year; and
- (b) employs at least two employees on the first day of the plan year.

Methodology for implementing the participation of small employer groups

The Health Insurance Exchange defined contribution market was open for initial registration and enrollment on a limited basis beginning in August of 2009, for coverage effective January 1, 2010. The initial registration was limited to approximately 150 employers. The Plan of Operation has been established with the ability to support other enrollment. Ongoing monthly enrollment for small employers is scheduled to begin in September 2010 for coverage effective on or after January 1, 2011.

Large Employers

A "larger employer," in connection with a health benefit plan, means an employer who, with respect to a calendar year and to a plan year:

- (a) employed an average of at least 51 eligible employees on each business day during the preceding calendar year; and
- (b) employs at least two employees on the first day of the plan year.⁴

Methodology for implementing the participation of large employer groups

A large group pilot planned for 2010 will result in participating employers having the option of enrolling their employees with effective dates as early as January 1, 2011. All Large Employers will be able to enrolled in the defined contribution market for coverage effective dates of January 1, 2012. The methodology for implementing the participation of large employers will be to work closely with the large group pilot partners during the pilot

³ Utah Code Ann., § 31A-1-301(154)(2010)

⁴ Utah Code Ann., § 31A-1-301(93)(2010)

program. Key decisions regarding their participation will be made at the monthly board meetings during the pilot program with the expectation that those procedures will establish the framework for implementing the participation of all large group employers. The Board will establish a framework and timeline for implementing a procedure to facilitate large group entry by January 1, 2012.

For large employer groups in the Exchange, a health questionnaire is required at the time of application for groups of 51-99, and at the time of enrollment for groups of 100 or more. A health questionnaire is an electronic application used for all employers to collect information regarding applicants' current and prior health conditions used for rating the group and calculation of the risk adjustment.

For groups of 51-99, insurer's rates will be determined using the same methodology of having a primary, secondary and mediator insurer randomly assigned, in the same manner as is done in the small employer group side of the Exchange. This information will be used to determine risk factors in the same methodology for each subscriber.

For large employer groups of 100 or more employees, rates will be determined by each insurer using information currently submitted and required. The health questionnaire will not be used in rate determination, but in a manner consistent with the groups of 51-99, where the primary, secondary and mediator insurers assign a risk factor to each subscriber. The risk adjustment mechanism is consistent with what is currently being done in the small employer market. The large employer groups will be separate and experience will not be commingled with the small employer groups. The retrospective pooling method will be the same methodology for small employer groups, again with no commingling.

For large employer plans, the prospective risk adjuster will be used in conjunction with a health questionnaire and a retrospective adjuster using the same methodology and corridor as small employer plans.

Employer Requirements

An employer participating in the defined contribution market is prohibited from offering a major medical health plan that is not part of the defined contribution arrangement. This does not prohibit the offer of supplemental or limited benefit policies such as dental or vision coverage, or other types of federally qualified savings accounts for health care expenses.⁵

To comply with Utah Code Ann. § 31A-42-202(2), this plan sets forth parameters that an employer may use to establish criteria for employee eligibility for enrollment. Once established, employers may only change these criteria at the annual open enrollment. The board, from time to time, may revise eligibility guidelines through this plan. See, Appendix D, "Life Events Grid," which lists the events upon which an employee may change health

⁵ Utah Code Ann., § 31A-30-204 (1)(a)

insurance plans at times other than open enrollment, and is incorporated herein by this reference.

Employee eligibility guidelines must be consistent with federal Health Insurance Portability and Accountability Act (HIPAA) and protect insurance carriers from adverse selection in the defined contribution market.⁶ See, Appendix E, “Employer Underwriting Workflow,” incorporated herein by this reference.

The employer must establish a mechanism for employees to make their premium contributions using pre-tax dollars. This can include an Internal Revenue Code, Section 125, Cafeteria Plan, Health Reimbursement Arrangement, or other plans approved by the IRS.⁷

The employer shall designate a default plan and notify the employees that they will be enrolled in the default health plan selected by the employer unless the employee, within the required time frame:

- Notifies the employer that the employee has selected a different health benefit plan available through the Exchange;
- Provides proof of coverage from another health benefit plan; or
- Specifically declines coverage in a health benefit plan.⁸

The Board interprets Utah Code Ann., § 31A-30-204(2)(b) to include plans limited to Utah domiciled employees.

The employer must offer each eligible employee a choice of any health plan for which the employee is eligible through the defined contribution arrangement on the Exchange.⁹

Employers may make changes only during renewal. Employees may elect a plan or make a change in their election during open enrollment, renewal or during special enrollments triggered by qualifying events.¹⁰

Premium must be remitted in compliance with the participation registration.

Enrolling employers must provide complete information as required by the Plan Enrollment Administrator (“PEA”).

⁶ Utah Code Ann., § 31A-42-202(2)(a)(ii)

⁷ Utah Code Ann., § 31A-30-204 (2)(a) and (b)

⁸ Utah Code Ann., § 31A-30-204(2)(b)

⁹ Utah Code Ann., § 31A-30-204 (2)(b)(ii)

¹⁰ Utah Code Ann., § 31A-30-208

Section 5 - General Exchange Participation Rules and Underwriting Requirements

Participating employers must sponsor the health benefit plan and implement an IRS Section 125 Cafeteria plan, Health Reimbursement Arrangement or other similar plan so employees may have the advantage of being able to purchase coverage in a tax-favored manner.

An employer group must enroll and maintain at least 75% of their employees in the defined contribution plans to be eligible for coverage in the Exchange.

The participation percentage is calculated as follows:

$$\text{Participation \%} = \frac{\text{Enrolled Employees}}{EE - PT - S - N - C - W}$$

Where:

EE is the total number of employees on payroll regardless of hours worked

PT is the number of employees working less than 30 hours per week

S is the number of seasonal employees

N is the number of employees in a new hire period

C is the number of 1099 employees

W is the number of employees with valid coverage waivers

Valid coverage waivers include other group health coverage, Medicare, Medicaid, CHIP, Tricare, and other government-sponsored coverage.

An employer must enroll at least 2 eligible employees for the group to be eligible for coverage on the Exchange.

Dependent only coverage is not allowed.

An employer with employees not living in the State of Utah may participate if no more than 25% of the employees live out of state.

No profession will be excluded from participation.

Eligibility information and premium must be remitted via the Exchange within the timeframe specified in the participation agreement. A copy of the participation agreement is attached as Appendix M and incorporated herein by this reference.

Insurance producers selected by participating small employers will receive \$37 per participating employee per month commission for employers. For purposes of the large group pilot only, insurance producers receive commissions on a per employee per month basis, as determined by the participating large employer.

A call center will be funded through service fees built into the Exchange. There is no requirement for employers to use an insurance broker or producer within the Exchange. Those choosing not to use a broker or producer in the small employer group will have \$30 of the \$37 commission go into escrow; the remaining \$7 will fund the call center.

Insurers may not impose a premium surcharge in the defined contribution market for employer groups moving to the Exchange off-anniversary.

A participating insurer may request an employer to submit a copy of the employer's quarterly wage list to determine whether the employees for whom coverage is provided or requested are bona fide employees of the employer.¹¹

Participating insurers evaluate health information of potential enrollees using the uniform insurance application and assign specific risk adjustments as prescribed by the Board.¹²

Premium rates will be prorated for life events.

All new groups, even if the group previously refused coverage under the Exchange, will have its risk factor recalculated when joining the Exchange.

Renewal

At renewal, participants in the Exchange must be in an active enrollment period. Employees must review their plan choice each year. If the employee fails to actively select a plan choice, a plan will be determined for the employee who will: (Option 1) default to last year's plan, or its plan equivalent; or, if Option 1 is not available, (Option 2) default to the employer's current default plan.

¹¹ Utah Code Ann., § 31A-30-203 (2)(b)(i)(ii)

¹² Utah Code Ann., § 31A-42-202 (2)(a)(ii)

Section 6 - Insurer Participation and Offerings

Insurers must notify the Board of their intent to participate in the defined contribution market no later than September 1st for participation beginning in January of the following year.

Insurers must provide benefit information to the vendor responsible for health plan benefit comparison, enrollment and administration no later than October 1st.

Insurers electing to participate in the defined contribution market must agree to participate for a minimum of two years.¹³

An insurer who chooses to offer a health benefit plan in the defined contribution market must offer the following health benefit plans¹⁴:

- (a) the basic benefit plan, which:
 - i. is a federally qualified high deductible health plan;
 - ii. has a deductible that is within \$250 of the lowest deductible that qualifies under a federally qualified high deductible health plan, as adjusted by federal law; and
 - iii. does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible;
- (b) one health benefit plan with benefits that have an actuarial value at least 15% greater than the plan described in (a);
- (c) one health benefit plan that is a federally qualified high deductible health plan that has an individual deductible of \$2,500 and a deductible of \$5,000 for coverage including two or more individuals, and does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible;
- (d) one health benefit plan that is a federally qualified high deductible health plan that has a deductible that is within \$250 of the highest deductible that qualifies as a federally qualified high deductible health plan as adjusted by federal law, and does not exceed an annual out-of-pocket maximum equal to three times the amount of the annual deductible; and
- (e) the insurer's five most commonly selected health benefit plans that:
 - (i) include:
 - (A) the provider panel;
 - (B) the deductible;

¹³ Utah Code Ann., § 31A-30-208

¹⁴ Utah Code Ann., § 31A-30-205

- (C) co-payments;
- (D) co-insurance; and
- (E) pharmacy benefits; and
- (ii) are currently being marketed by the carrier to new groups for enrollment.

The provisions above do not limit the number of health benefit plans an insurer may offer in the defined contribution market. An insurer who offers the health benefit plans required may also offer any other health benefit plan in the defined contribution market if the health benefit plan provides benefits that are actuarially richer than the benefits required above. See, Appendix L, "Health Insurance Exchange Large Group Pilot Health Plan Options," which represents the five (5) most popular plans per Utah Code Ann. § 31A-30-205. In addition, plans with slight variations may be used, subject to the approval of the Utah Insurance Department. Appendix L is incorporated herein by this reference.

In addition to the minimum benefit plan requirements, the insurer must agree to provide data to the Utah All Payer Database.

Insurers agree to participate in the risk adjustment and reinsurance programs adopted by the Board. The Board may change the program from time to time. The Board may determine that a consultant or administrator is required to administer the program. The Board may initiate a fee to cover the cost of consulting or administrative services.

Section 7 - Premium Rate Determination

Rates in the defined contribution market are subject to the “Individual, Small Group and Group Health Insurance Act.”¹⁵

Subject to regulation by the Utah Department of Insurance, each insurer is responsible to set rates that comply with state law, including, but not limited to Utah Code Ann., §§ 31A-42-202(2)(a) and 31A-42-202(2)(b), the federal Health Insurance Portability and Accountability Act and the federal Patient Protection and Affordable Care Act.

Due to the nature of the Defined Contribution market, any rate adjustments for a specific group made for claims experience, health status, etc., must be made uniformly to all plans and rates offered to the group.

Rates shall be determined and provided to the Exchange in the following age bands:

- Less than 20
- 20-24
- 25-29
- 30-34
- 35-39
- 40-44
- 45-49
- 50-54
- 55-59
- 60-64
- 65 and above

Insurers shall use a standard slope ratio range for each age band, not to exceed an overall ratio of 5:1.¹⁶

To comply with Utah Code Ann, § 31A-42-202(1)(b)(i)(B), wellness incentives must be considered in determining individual rates.

The rates applicable to an employee and dependents shall be determined based on the employee’s age at enrollment for the current plan year. If an employee has a birthday that results in a change in age band, the change will not take effect until the next plan year.

Rates shall be in a four tier structure, as follows:

Employee only

¹⁵ Utah Code Ann., § 31A-30-106

¹⁶ Utah Code Ann., § 31A-30-106.1(6)

Employee + Spouse

Employee with child(ren)

Employee +Family (spouse and child(ren))

This four-tier structure will be the same for the large group pilot.

Insurers will submit premium rates to the Exchange net of any producer commissions and compensation, and net of any Exchange fees. Producer commissions and Exchange fees will be added to the premiums by the Exchange prior to presentment to employees. For employer bill presentment, commissions and fees will be shown separately from net premiums.

Rates provided by the Exchange to an employer may include producer commissions and other fees as approved by the Board. Rates will be valid for 12 months from their effective date, unless it is determined that the employer has failed to comply with the provisions outlined in Section 4 and Section 5.

Section 8 - Premium Distribution

The Exchange banking vendor is responsible for the collection and distribution of the premium. Distribution of the premium includes the following: payment of producer commissions; distribution of Exchange fees to the appropriate entities; and distribution of premium to the insurers. The Board has adopted a methodology for recognition of risk selection between insurers. This methodology requires that a specific factor be assigned all participants and that the participants of each insurer be weighted in the premium distribution. See, Appendix H for an example of premium distribution. Also, see, Appendices I, J, K, and L for further detail. Appendices H, I, J, K, and L are incorporated herein by this reference.

The banking vendor will distribute the premium on a monthly basis by the 28th of the month prior to the coverage month. Other distributions will occur in a timely manner.

Section 9 - Overview of Defined Contribution Market Workflows

Participating insurers in the Exchange will provide benefit information to the PEA no later than October 1 for the following January effective date.

The Exchange will establish a cutoff date for employer applications for coverage no less than 75 days before the desired effective date of coverage.

An open enrollment period will be held approximately 60 days prior to the coverage effective date and will last approximately 14-21 days. Eligible employees may choose or modify their plan choice during this open enrollment period.

Insurers must notify the Utah Insurance Department and the Board, by September 1, of their intent to enter or exit the Exchange on January 1 of the following year. Entering insurers must submit materials and rates by September 1 to be included in the open enrollment.

Insurers opting to participate in the Exchange must agree to participate for at least 2 years from January 1 of the first year through December 31 of the second year. Insurers participating agree to continue coverage through December 31.¹⁷ Insurers are responsible to meet with vendors to establish formats for the Exchange of data needed to develop data standards regarding plan enrollment and employee enrollment and any other data needing to be exchanged between the parties.

During the open enrollment the PEA responsible for health plan benefit comparison, enrollment, and administration, will facilitate registration by employers and enrollment of employees. This is a two-stage process whereby the employer registers and provides required information regarding the employer's eligibility to participate in the Exchange. The PEA will forward the employer information to the insurers for initial underwriting.

Other required group information and information specific to individuals will be transmitted to the insurers after the initial group eligibility is determined.

A risk factor for each employer group and each employee shall be determined through the underwriting process and provided to the PEA. The insurers will apply the risk factor and determine the final rates, then provide them to the PEA. The PEA will make the final rates and benefits available for selection through the Exchange.

The PEA will verify that the employer group meets the 75% participation requirement prior to the transmission of enrollment information to both the banking vendor and the selected insurers. If there is a question regarding a group's eligibility, the PEA will refer the group to

¹⁷ Utah Code Ann., § 31A-30-208

the primary underwriting insurer for review. The PEA will also determine if there has been a change in census and will forward all changes to the primary and secondary underwriting carriers to determine risk factors and rates. Any changes to group or individual applications will be identified by the PEA and provided to the primary and secondary underwriting carriers. If the risk factor changes as a result of these modifications, the PEA will notify all carriers to recalculate and submit updated rates.

The banking vendor will transfer premium via electronic funds transfer, or other method from the participating employers according to the agreed upon schedule.

The banking vendor will separate Exchange fees, producer commissions, and net premiums, and send them with remittance advice to the appropriate parties.

In determining the allocation of premium to the insurers, the banking vendor will first assure that the proper amount of premium has been collected from each employer. Second they will determine amount of premium due each insurer, based on billed rates. The banking vendor will then apply the risk adjustment methodology prescribed by the Board and outlined in Appendices I and J to determine the premium revenue allocation.

A retrospective settlement will be calculated in August of each year to allow for 6 months of claims run-out from the previous calendar year. Insurers remitting money shall send the money to the banking vendor within 15 days of receipt of the invoice from the Board. When all of the payments are received, the banking vendor will distribute monies as directed by the Board.

Work flow diagrams for the various efforts are included in Appendices E through J, and are incorporated herein by this reference.

Outline of the Mechanism for Adjusting Risk Between Insurers

The amount of total risk insured through the defined contribution market is calculated each month as follows:

- Each employee is given a health risk factor through the process outlined above.
- Conditions that may be counted in this risk factor include factors typically used in the underwriting process by insurers.
- The weight given to each health condition will be based on standard industry methodology.
- The total amount of risk is the sum of the individual risk scores.

The amount of total risk for each insurer is the subtotal of total risk by insurer.

The amount of premium given to each insurer is proportional to the percent of total risk insured to the insurer.

By definition the amount of risk adjustment is the difference between the total amount of net premium (net of fees and expenses) paid by those insured by a given insurer and the amount of premium received by the insurer as calculated here.

To comply with Utah Code Ann. § 31A-42-202(2)(a)(ii), protections for insurance carriers from adverse selection are set forth in Appendices F, G, and H.

Section 10 - Appeals

Operational Appeals

Operational appeals must be submitted in writing to the Utah Insurance Department, who will coordinate with the appropriate subcommittee for determination. The Small Group Underwriting Subcommittee will handle matters dealing with small groups; the Large Group Underwriting Subcommittee will handle matters dealing with large groups. If a resolution is not reached, the matter may be heard by the Risk Adjuster Board.

Operational appeals include:

- Determination of an employer's eligibility for the coverage on the Exchange; and
- Determination of eligibility of individual employee waivers.

Claims Appeals

Claim payment appeals follow Utah insurance regulations and should be directed to the specific insurer involved.

Section 11 - Financial Reporting and Audits

Financial Reporting

The Board will establish workflows to facilitate regular monitoring and reporting of the financial performance of individual employer groups and the Exchange as a whole. Any financial transactions that involve the board directly (such as fees collected and disbursed to pay for an independent actuary, consultant or administrator) will be conducted through the Insurance Department's financial system. Insurance Department staff will keep records of all such transactions and will send an annual report to the Commissioner and to the Board.

Audits

The Board reserves the right to request audits of the following:

- Functional workflows performed by contracted vendors
- PEA & Banking
 - Appropriate charge
 - Allocation
- The Office of Consumer Health Services (OCHS)
 - Responsible for contract compliance
- Participating Employers
 - Verify eligibility

All audits will be consistent with contracts and regulations in place at the time of the audit.

Section 12 - Independent Actuary

Pursuant to Utah Code Ann. 31A-42-202(3), the board will contract with an independent actuary for the purpose of reviewing premium rates on the Health Insurance Exchange. The specific duties of this actuary include:

- Reviewing information submitted by insurers to verify the validity of rates, rating factors, and premiums and verifying underwriting and rating practices as the actuary determines necessary.
- Reporting aggregate data to the board
- Contacting particular insurers to inform them of findings regarding their information or to request that they re-calculate or verify base rates, rating factors, and premiums
- Sharing analysis and data with the Department of Insurance as required by Utah Code 31A-30-106.1

The board will use state purchasing procedures to submit a request for proposal (RFP) for independent actuaries. As part of the RFP process, the contract with the winning bidder will include the following elements in consultation with the winning bidder:

- A mechanism for plans to submit information to the actuary
- A fee to compensate the actuary for services

Insurers will be required to re-submit premium rates if they are contacted by the Department of Insurance due to issues raised in this process.

The board will assess fees to pay the actuary to all small group insurers participating in the defined contribution arrangement as well as small employer insurers offering health plans under Utah Code Annotated, Chapter 30, Part 1. The fees must follow the requirements of Utah Code Ann. § 63J-1-504.

The allocation of the fees to the insurers will be pro-rated based on the total number of commercially insured small group and defined contribution lives in the State of Utah.

For the review of 2011 rates, the funding for the Independent Actuary will be assessed for a total of up to \$150,000, in three equal installments. The assessment is based on active lives from the information available in the latest available health survey.

Section 13 - Changes to Plan of Operation

Pursuant to Utah Code Ann., § 31A-42-202(2)(e), changes may be made to this Plan of Operation, if necessary to :

- (1) incorporate large group plans into the risk adjuster;
- (2) maintain proper functioning and solvency of risk adjuster;
- (3) mitigate risk selection; and
- (4) improve administration of risk adjuster, including opening enrollment for the purpose of testing risk adjusting process.

Amendments to the Plan of Operation are effective when adopted by the Commissioner through administrative rules.¹⁸

¹⁸ Utah Code Ann. § 31A-42-204(2)

Appendix A - Articles of Organization

Utah Defined Contribution Risk Adjuster

Articles of Organization

Pursuant to Utah Code Ann. Title 31A, Chapter 42, the following constitutes the organizational articles of the Utah Defined Contribution Risk Adjuster (the “Risk Adjuster”), a non-profit entity within the Utah Insurance Department (the “Department”).

Article I. Name

This entity shall be known as the **Utah Defined Contribution Risk Adjuster**, hereinafter referred to as the Risk Adjuster, a non-profit entity created by Utah Code Ann. Title 31A, Chapter 42, hereinafter referred to as the Act.

Article II. Address

The official address of the Risk Adjuster is Utah Insurance Department, State Office Building, Suite 3110, Salt Lake City, Utah 84114-6901.

Article III. Effective Date

These articles, the bylaws and any amendments to either shall become effective following adoption by the board of directors (the “Board”) of the Risk Adjuster and upon approval by the Utah Insurance Commissioner (“Commissioner”)

Article IV. Purpose

The purpose of the Risk Adjuster is to establish a Board within the Department that is given the responsibility to develop a risk adjustment mechanism that will apportion risk among the insurers participating in the Health Insurance Exchange, a defined contribution market to protect insurers from adverse risk selection, created pursuant to Title 63M, Chapter 1, Part 25, Health System Reform Act. The Risk Adjuster will also implement, administer and enforce Title 31A, Chapter 42, the Defined Contribution Risk Adjuster Act, and assist the Governor’s Office of Consumer Health Services in developing the Health Insurance Exchange, the defined contribution state-facilitated health insurance portal in the State of Utah.

Article V. Definitions from the Act

Where applicable, terms used in these articles and the bylaws shall be as defined in Section 202 of the Act.

Article VI. Conformity to the Act

The Act is hereby incorporated as part of these articles and the bylaws. In the case of any conflict between these articles, bylaws and the Act, the provisions of the Act shall govern.

Article VII. Membership

The Risk Adjuster is a statutorily created nonprofit entity within the Department and shall have no members. Employees, employers and insurers participating in the Health Insurance Exchange are not members and have no rights of membership in the Risk Adjuster, including the right to nominate and elect the members of the Board of the Risk Adjuster.

Article VIII. Board of Directors

The Board of the Risk Adjuster shall be appointed by the Governor and shall serve as directors for the terms provided for in Section 201 of the Act. The Board shall conduct the business of the Risk Adjuster in accordance with Section 203 of the Act.

Article IX. Audit

The Board shall cause the Risk Adjuster to have a fiscal year financial audit by the State Auditor and will submit the audit report by December 1 of each year to the Commissioner in a form approved by the Commissioner.

Article X. Immunity

Members of the Board, the Board's agents, employees and the Commissioner are immune from liability as provided by state law.

Article XI. Duration and Limitations

The Risk Adjuster shall exist until the legislation that created it is repealed. In the event of dissolution of the Risk Adjuster, all assets remaining after the windup of its affairs shall enure to the benefit of the State of Utah.

The Risk Adjuster shall not afford pecuniary gain, incidentally or otherwise, to any member of the Board or any individual or to any corporation, provided that this article shall not prevent the payment to any individual or corporation of such reasonable compensation for services rendered to the Risk Adjuster or other payments necessary in effectuating any of its purposes.

Article XII. Amendments

The articles, bylaws and plan of operation may be altered or amended at any meeting of the Board. Amendments shall be by majority vote of the quorum of the Board. Any amendments shall become effective following adoption by the Board upon approval of the Commissioner.

Dated: October 26, 2010

Appendix B - Bylaws

UTAH DEFINED CONTRIBUTION RISK ADJUSTER BYLAWS

Pursuant to Utah Code Ann. Title 31A, Chapter 42, hereinafter referred to as the Act, as said law may be amended from time to time, the following constitutes the Bylaws of the Utah Defined Contribution Risk Adjuster, a non-profit entity within the Utah Insurance Department ("Department"), hereinafter referred to as (the "Risk Adjuster").

ARTICLE I. THE BOARD OF DIRECTORS

Section 1. General Powers. The affairs of the Risk Adjuster shall be managed by its Board of Directors, ("Board") subject only to such approval of the Utah Insurance Commissioner ("Commissioner") as required by law. The Risk Adjuster shall at all times be managed by its Board, which shall at all times consist of up to nine (9) individuals or as may be increased or changed by law in the future. The Board shall have the powers granted in Section 203 of the Act.

Section 2. Composition. The composition of the Board shall be as now provided in the Act or as it may be amended, and shall consist of:

- a. At least three, but up to five, directors with actuarial experience representing insurance carriers that are participating or have committed to participate in the defined contribution arrangement market in Utah, including at least one and up to two directors that represent a carrier that has a small percentage of lives covered in the defined contribution market;
- b. One director who represents either an individual employee or employer participant in the defined contribution market in Utah;
- c. One director representing the Office of Consumer Health Services within the Governor's Office of Economic Development;
- d. One director representing the Public Employees' Benefit and Health Insurance Program with actuarial experience, appointed by the director of the Public Employees' Benefit and Insurance Program; and
- e. The Commissioner or a representative of the Commissioner who is appointed by the Commissioner and has actuarial experience, who will only have voting privileges in the event of a tie vote.

Section 3. Tenure. Except as otherwise provided by the Act, board members shall serve for a term of four (4) years. All board members shall hold office until their successors are duly appointed. However, in order to provide for staggered terms, some board members shall be appointed initially for terms of less than four (4) years so that approximately half of the Board is appointed every two years. Each board member may, if reappointed, serve successive terms without limit unless the Governor's policy relating to appointments to boards and commissions provides otherwise.

Section 4. Vacancies. Any vacancies occurring in the Board shall be appointed for the unexpired term in the same manner as the original appointment was made.

Section 5. Actions of the Board. The Board shall have the power to:

- a. Use their powers as necessary and appropriate to accomplish the objectives of the Risk Adjuster;
- b. Elect a Chairperson, Vice Chairperson, and such other officers as are deemed necessary. The duties and responsibilities of such officers shall be as designated in the Bylaws; and
- c. Establish policies and procedures, as necessary, to facilitate adequate and appropriate levels of operation of the Risk Adjuster.

Section 6. Regular Board Meetings. The Board will meet no less than monthly at the office of the Utah Insurance Department or other designated place.

Section 7. Special Meetings. Special meetings of the Board may be called at the request of the Chairperson or any three (3) voting board members. The times and places for such special meetings shall be set by agreement of the Chair and the board members requesting the meeting.

Section 8. Notice. Notice of any regular or special meeting of the Board shall be given at least twenty-four (24) hours prior to the meeting and shall be posted in a public place at the Department, on the Utah Public Meeting Notice website, and other appropriate public places. Such notice shall be delivered personally or sent by mail or e-mail to each board member and to the Commissioner at their addresses as shown in the records of the Risk Adjuster. An emergency meeting may be held upon twenty- four (24) hours oral notice, provided each member of the Board has reasonable opportunity to attend. If mailed, such notice shall be deemed to be delivered when deposited in the United States mail in a sealed envelope so addressed with postage prepaid. If notice is given by e-mail, such notice shall be deemed to have been given when the e-mail is sent and does not result in notice of non-delivery. Board members are required to maintain a current e-mail account and to notify the Department of any address changes. Any board member may waive notice requirements of any meeting. The attendance of a board member at any meeting shall constitute a waiver of notice of such a meeting, except when a board member attends a meeting for the express purpose of objecting to the transaction of any business because the meeting is not lawfully called or convened.

Section 9. Voting Quorum. The presence of a majority of the board members shall constitute a quorum for the transaction of business.

Section 10. Manner of Acting. The act of a majority of a quorum of board members present at a meeting shall be the act of the Board, unless the act of a greater number is required by law or by these Bylaws. The Commissioner or his/her representative shall not vote except in the event of a tie vote of the Board. The Chair of the Board shall always vote and be recorded in all matters with the vote of any other board member. An affirmative vote by the

majority of the members of a quorum is required to constitute an act of the Board. Board action is required to:

- a. Approve contracts with any person or organization to perform administrative activities and duties on behalf of the Risk Adjuster;
- b. Remove a board member;
- c. Initiate any legal proceeding; or
- d. Exercise the powers and perform the duties required of the Board under Section 203 of the Act.

Section 11. Voting. Each board member present shall be entitled to one vote on each matter submitted to a vote of the Board. Board members shall disclose any conflict of interest, as defined in policy, to the Board.

Section 12. Compensation and Expense. Board members who are not government employees shall receive no compensation or benefits for their services. Board members who are also state government employees may not receive per diem or expenses for their services. Cost of conducting the meeting of the Board shall be borne as administrative costs of the Risk Adjuster. Nothing herein precludes a board member from serving the Risk Adjuster in any other capacity and receiving compensation therefore.

Section 13. Conference Telephone Meetings. Meetings of the Board or any committee of the Risk Adjuster may be held by means of a conference telephone, video conferencing or similar communication by means of which all persons participating in the meeting can hear each other. Participation by such means shall constitute the presence of a person at a meeting. Notice of the time and the manner of such meeting shall be given in accordance with Section 10 of this Article of the Bylaws.

Section 14. Immunity. Immunity shall be provided, as available, pursuant to the Utah Governmental Immunity Act under Sections 63G-7-101 et. seq.

ARTICLE II. OFFICERS

Section 1. Annual Election of Officers. The Board shall annually elect from its members a Chairperson of the Board and a Vice Chair. New offices may be created and filled at any meeting of the Board. All officers shall hold office at the pleasure of the Board.

Section 2. Removal. Any officer elected or appointed by the Board may be removed, with or without cause, by a majority vote of the Board (See Article I, Section 11).

Section 3. Vacancies. A vacancy in any office created under this section that occurs because of death, resignation, removal, disqualification or otherwise, shall be elected by the Board for the unexpired portion of the term.

Section 4. Chairperson of the Board. The Chairperson of the Board shall be the Chief Executive Officer of the Risk Adjuster and shall have the power to call meetings of the members of the Board, set the agenda, and the Chairperson or the Chair's designee shall preside at all such meetings of the Board. The Chairperson shall also have the power to call emergency meetings of all committees established by the Board. The Chairperson of the Board shall have power for and in the name of the Risk Adjuster to execute with the Vice Chair such instruments as may be authorized by the Board including but not limited to bonds, contracts, or other instruments.

Under the direction of the Board, the Chairperson shall have the power to execute health insurance contracts, reinsurance contracts, provider contracts, administrative contracts and other obligations, and the power to make and execute contracts in the ordinary course of business of the Risk Adjuster.

Section 5. Vice Chair of the Board. In the absence of the Chairperson, the Vice Chair shall perform the duties of the Chair. When so acting, he or she shall have all the powers of, and be subject to, all the restrictions upon the Chair. The Vice Chair shall perform such other duties as may be assigned by the Chairperson or by the Board.

ARTICLE III. COMMITTEES

Section 1. Committees.

a. **Formation.** The Board may designate and appoint one or more committees, as deemed necessary by the Board. Each committee shall consist of two or more board members or such other members as may be designated by the Board. The designation and appointment of any such committee and the delegation thereto of authority shall not operate to relieve the Board, or any individual board member, of any responsibility imposed upon him or her by law.

b. **Term.** Each member of the committee shall serve at the pleasure of the Board.

c. **Vacancies.** Vacancies in the membership of any committee may be filled by appointments made in the same manner as provided in the case of the original appointments.

ARTICLE IV. RECORDS AND REPORTS

Section 1. Fiscal Year. The fiscal year of the Risk Adjuster shall end June 30 of each calendar year.

Section 2. Market Report. The Board is to prepare and submit annually to the Department for inclusion in the Department's annual market report, an annual report which includes:

- a. The expenses of administration of the Risk Adjuster in the defined contribution market;
- b. The description of the types of policies sold in the defined contribution market;
- c. The number of insured lives in the defined contribution market; and

- d. The number of insured lives in health benefit plans that do not include state mandates.

Section 3. Budget Report. The Board is to prepare and submit annually to the Department the following:

- a. A budget forecast of the operation of the Risk Adjuster; and
- b. A proposed budget for the administration of the Board.

Section 4. Report of Health Reform Task Force. The Board shall report to the Health Reform Task Force and to the Legislative Management Committee prior to October 1, 2009 and again prior to October 1, 2010 regarding:

- a. The board's progress in developing the Plan of Operation as required by the Act;
- b. The board's progress in:
 - (1) Expanding choice of plans in the defined contribution market; and
 - (2) Expanding access to the defined contribution market in the Internet portal for large employer groups.

Section 5. Books, Records and Minutes. The Board shall cause to be kept correct and complete books and records of all accounts. Written minutes and a recording shall be kept of the proceedings of each Board meeting. The original of these records shall be retained by the Department. Copies of such minutes shall be furnished to each board member and to the Commissioner. All books and records of the Risk Adjuster may be inspected by the public pursuant to the Government Records Access and Management Act, Utah Code Ann., Title 63G, Chapter 2.

ARTICLE V. OPEN MEETINGS

All meetings of the Board shall be held pursuant to the Open and Public Meetings Act, Utah Code Ann., Title 52, Chapter 4.

ARTICLE VI. OPERATING RULES

The Board will coordinate all requests for Risk Adjuster disbursements and deposits with an employee of the Department designated by the Commissioner. All such deposits or disbursements will be debited or credited to the account of the Risk Adjuster, as required by state finance policy and procedures.

ARTICLE VII. INDEMNIFICATION OF DIRECTORS, OFFICERS, EMPLOYEES AND AGENTS

Each Officer, Board Member, Employee, Contractor, or Agent of the Risk Adjuster, whether or not then in office, shall be indemnified by the Risk Adjuster against all liabilities, costs and expenses reasonably incurred by or imposed upon him or her in connection with or arising out of any action, suit, or proceeding, in which he or she may have been involved or to which he or she may be made a party by reason of being or having been an Officer, Board Member, Employee, Executive Director, Contractor, or Agent of the Risk Adjuster, to the extent and in

the manner allowed by the Utah Revised Nonprofit Corporation Act, Utah Code Annotated, Section 16-6a-901 through 910.

Dated: October 26, 2010

Appendix C - Electronic Meetings Resolution



State of Utah

GARY R. HERBERT
Governor

GREG BELL
Lieutenant Governor

D. KENT MICHIE
Insurance Commissioner

Insurance Department

RESOLUTION TO PERMIT ELECTRONIC MEETINGS

UTAH DEFINED CONTRIBUTION RISK ADJUSTER BOARD

WHEREAS, the Utah Defined Contribution Risk Adjuster Board of Directors (hereinafter "Board"), finds it necessary, on occasion, to hold meetings by electronic means,

WHEREAS, the Utah Open and Public Meetings Act, changes effective May 1, 2006, mandates that a public body may not hold an electronic meeting unless the public body has adopted a resolution, rule, or ordinance governing the use of electronic meetings;

BE IT RESOLVED that meetings of the Board or any committee of the Utah Defined Contribution Risk Adjuster (hereinafter "UDC Risk Adjuster") may be held by means of a conference telephone, video conferencing or similar communication by means of which all persons participating in the meeting can hear each other. Participation by such means shall constitute the presence of a person at a meeting. Notice of the time and manner of such meeting shall be given in accordance with Article I, Section 9 of UDC Risk Adjuster Bylaws and in accordance with the Utah Open and Public Meetings Act.

The Board hereby adopts the foregoing resolution this 29th day of July, 2009.

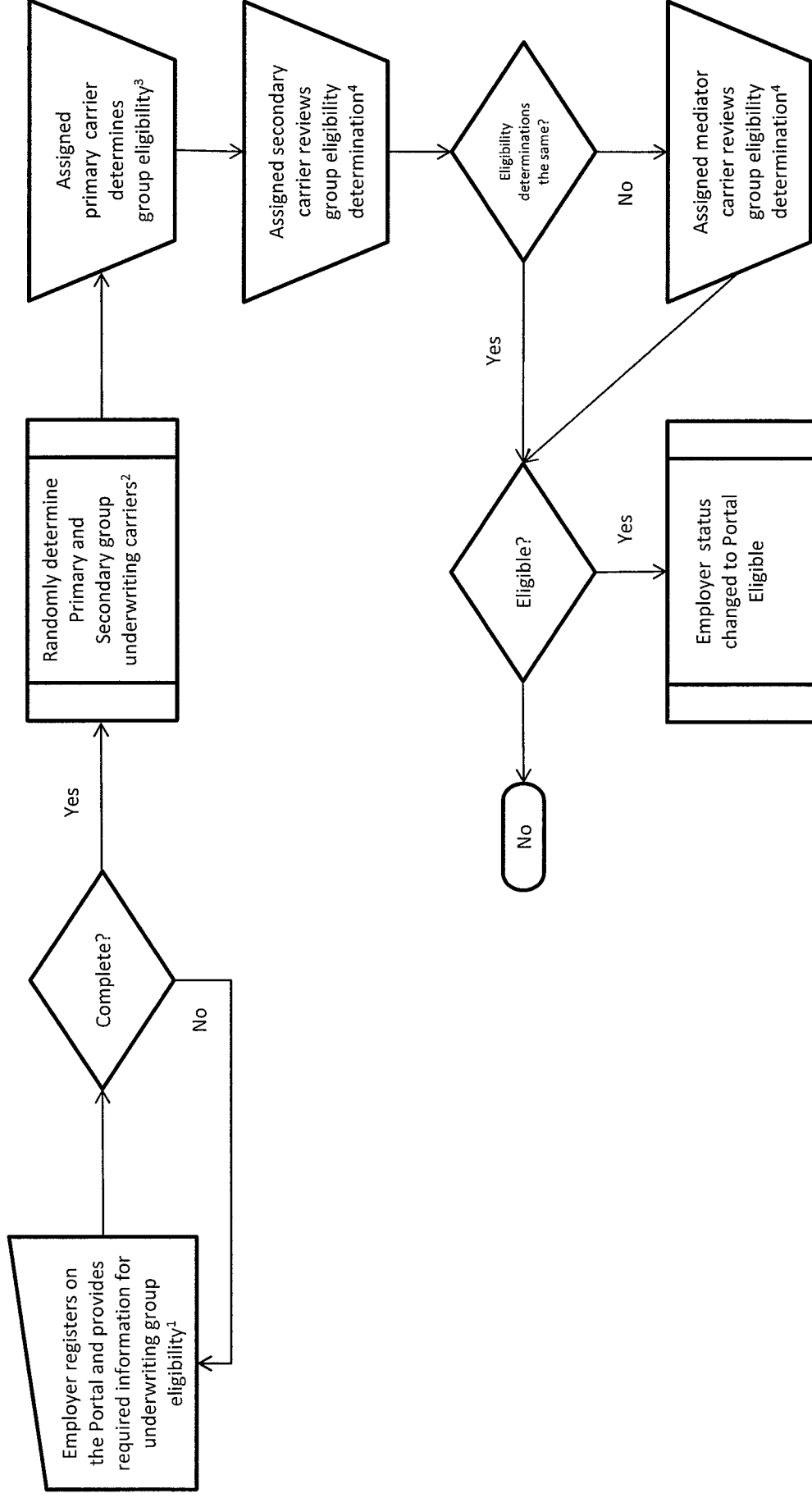
A handwritten signature in black ink, reading "Mark Brown".

Mark Brown
Chairman of the Board

Appendix D - Life Events Grid

[illegible]

APPENDIX E **Defined Contribution Portal** **Employer Underwriting Workflow**



APPENDIX E

Defined Contribution Portal

Employer Underwriting Workflow

Notes:

¹ Required information includes:

- Company Name
- Company Address
- Company Key Contact
- Company Billing Address (if different from above)
- Federal Tax ID #
- Number of years in business
- Total number of full-time employees now
- Total number of full-time employees now one year ago
- Census of employees & dependents (including those eligible or on COBRA, Utah mini-COBRA, or Alternative Coverage)
- Copy of most recent Quarterly Wage & Tax form; if in business less than one year, current payroll listing
- Copy of most recent prior carrier billing information
- Copy of Business License or Articles of Incorporation
- Current Group Carrier and Coverage Dates
- Name of Producer
- Producer License #

² System will randomly select a Primary, a Secondary, and a Mediator carrier from among the participating carriers to perform the group underwriting.

³ Groups and employee types NOT eligible for the Portal:

- Associations
- Employee Leasing Companies (e.g., PEOs)
- Groups of 1 employee (employed dependents may not be separated for purposes of group qualification)
- Groups with more than 25% of enrolled employees living or working outside the State of Utah
- Part-time employees
- 1099 employees
- Retirees

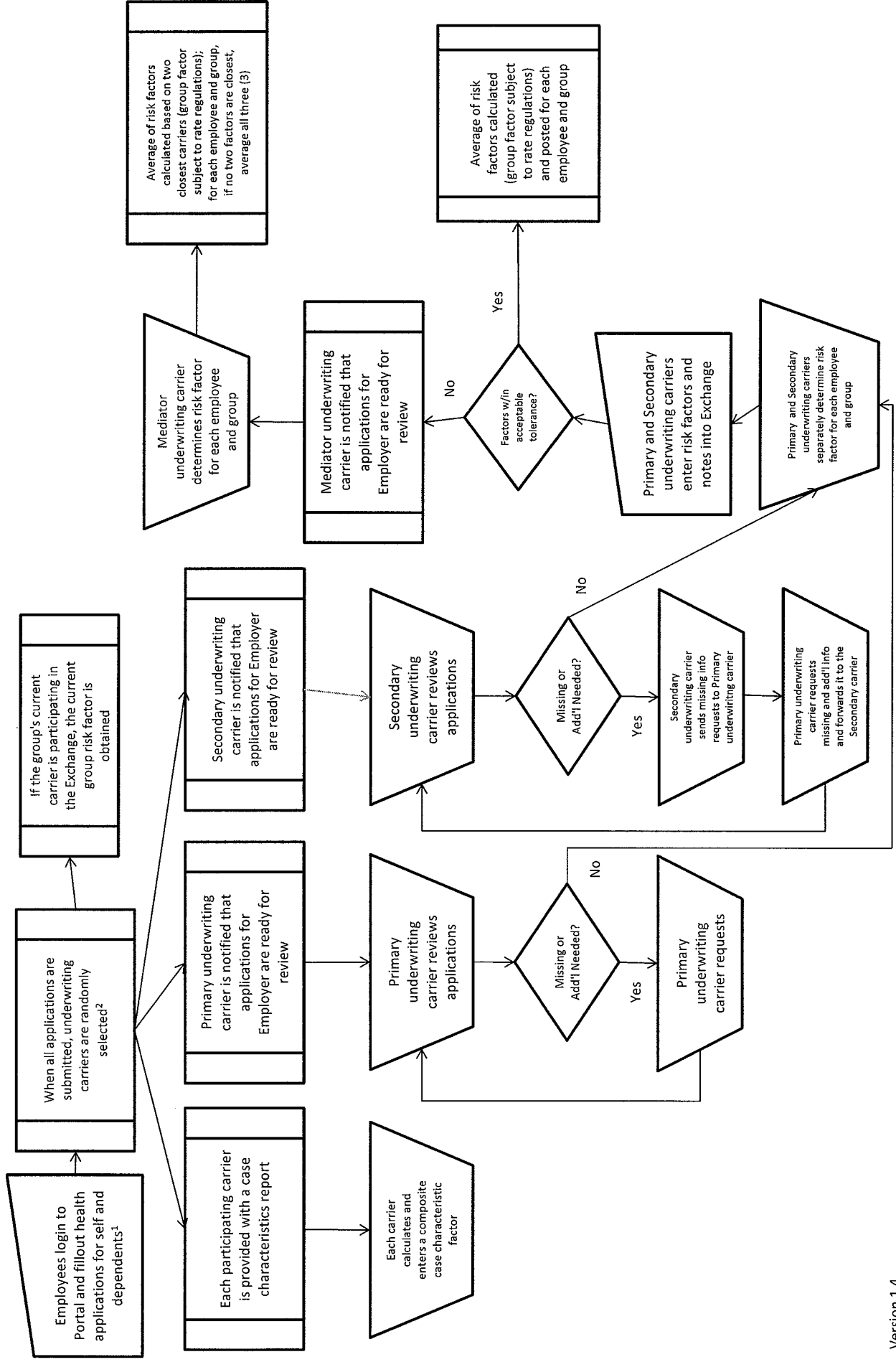
⁴ If difference of opinion between the Primary and Secondary underwriting carriers regarding eligibility, the Mediator underwriting carrier will also review the information to determine eligibility. If a Mediator underwriting carrier is used, the majority decision of the three underwriting carriers is the eligibility determination.

APPENDIX F

Defined Contribution Portal

Risk Rating (Initial) Workflow

For Portal-Eligible Employers



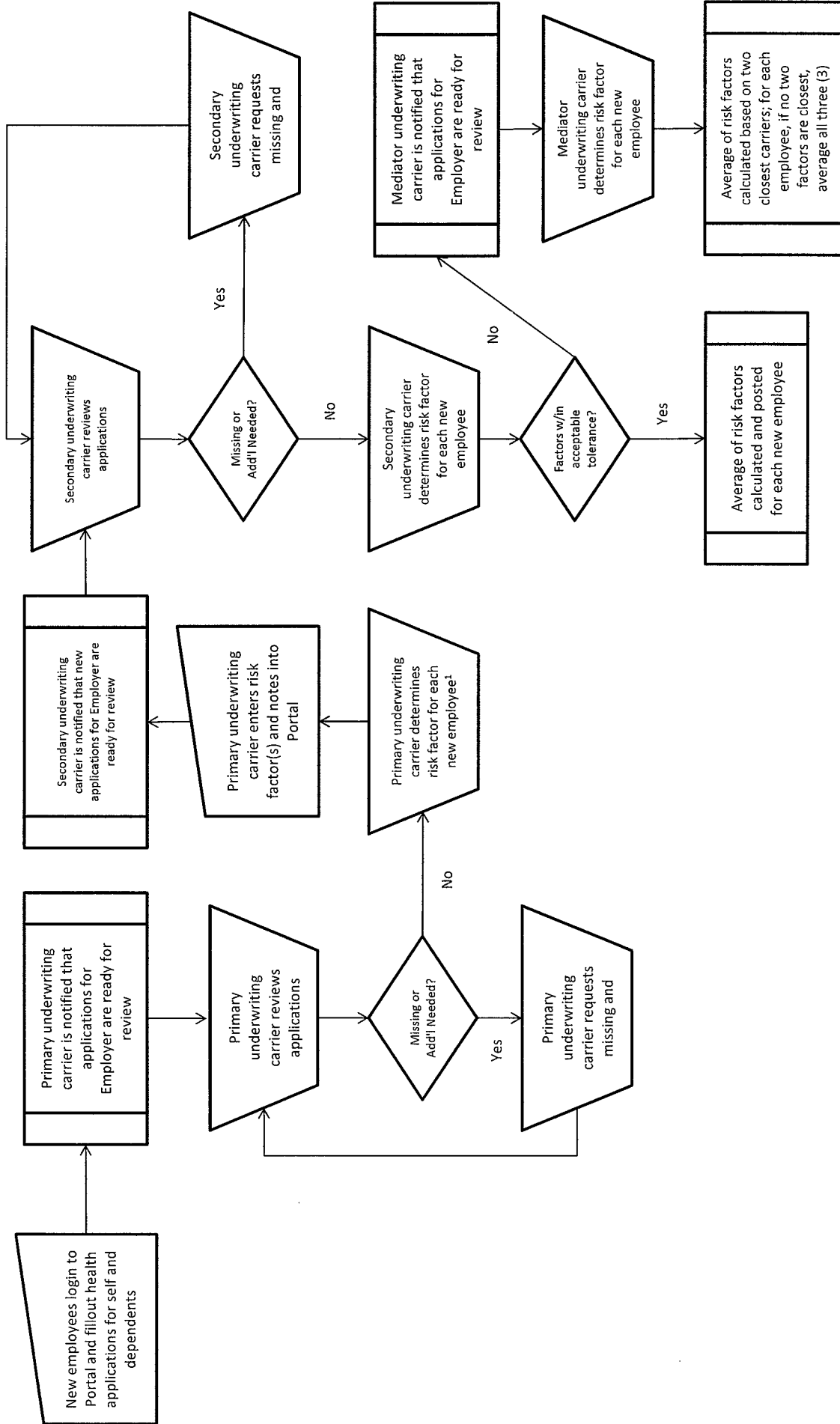
APPENDIX F
Defined Contribution Portal
Risk Rating (Initial) Workflow

Notes:

¹ Required for all employees regardless of whether or not they expect to enroll.

APPENDIX G **Defined Contribution Portal** **Risk Rating (Monthly Update) Workflow**

For Previously Rated Employers

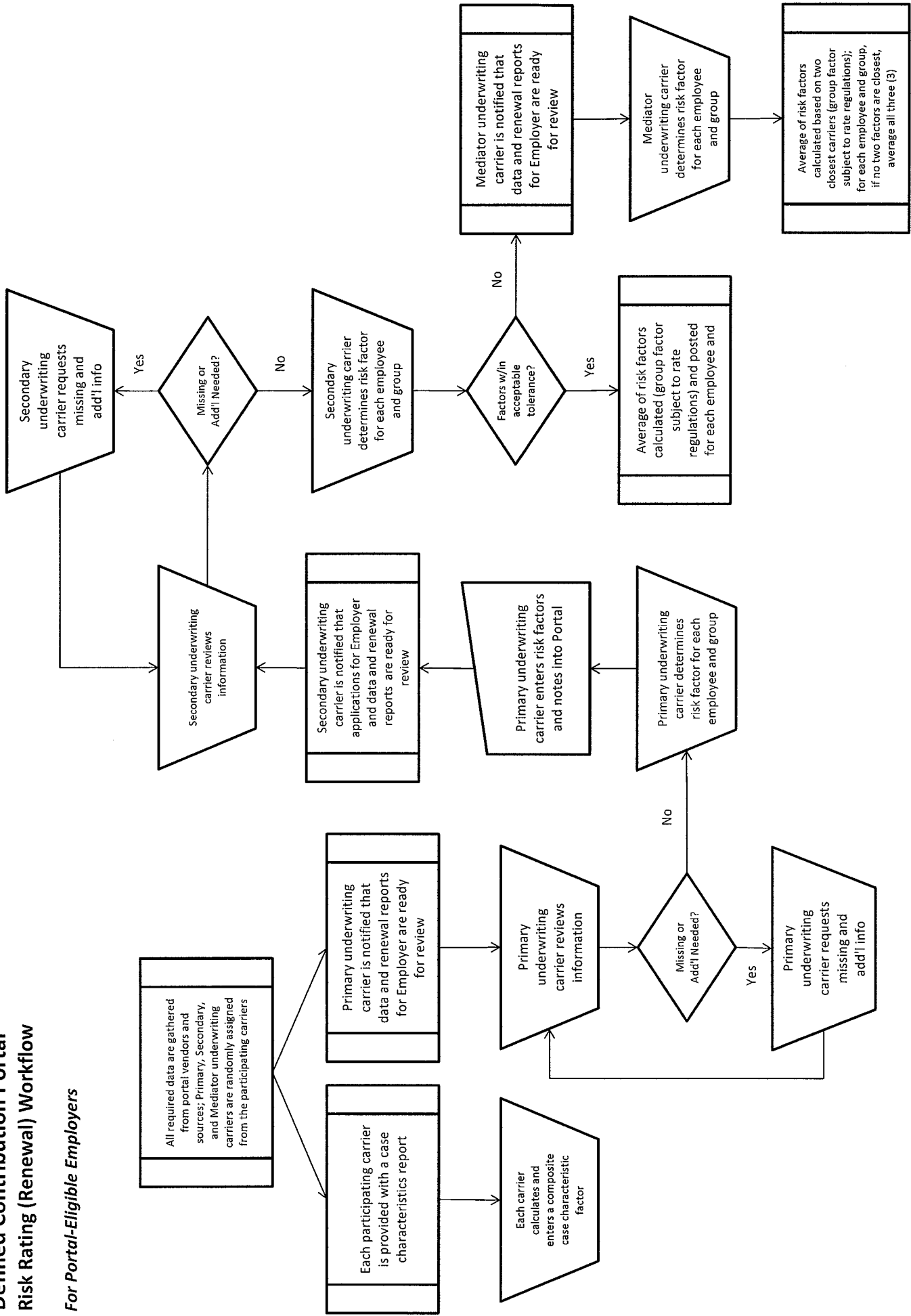


APPENDIX G
Defined Contribution Portal
Risk Rating (Monthly Update) Workflow

Notes:

¹ Group factor does not change.

APPENDIX H **Defined Contribution Portal** **Risk Rating (Renewal) Workflow** *For Portal-Eligible Employers*

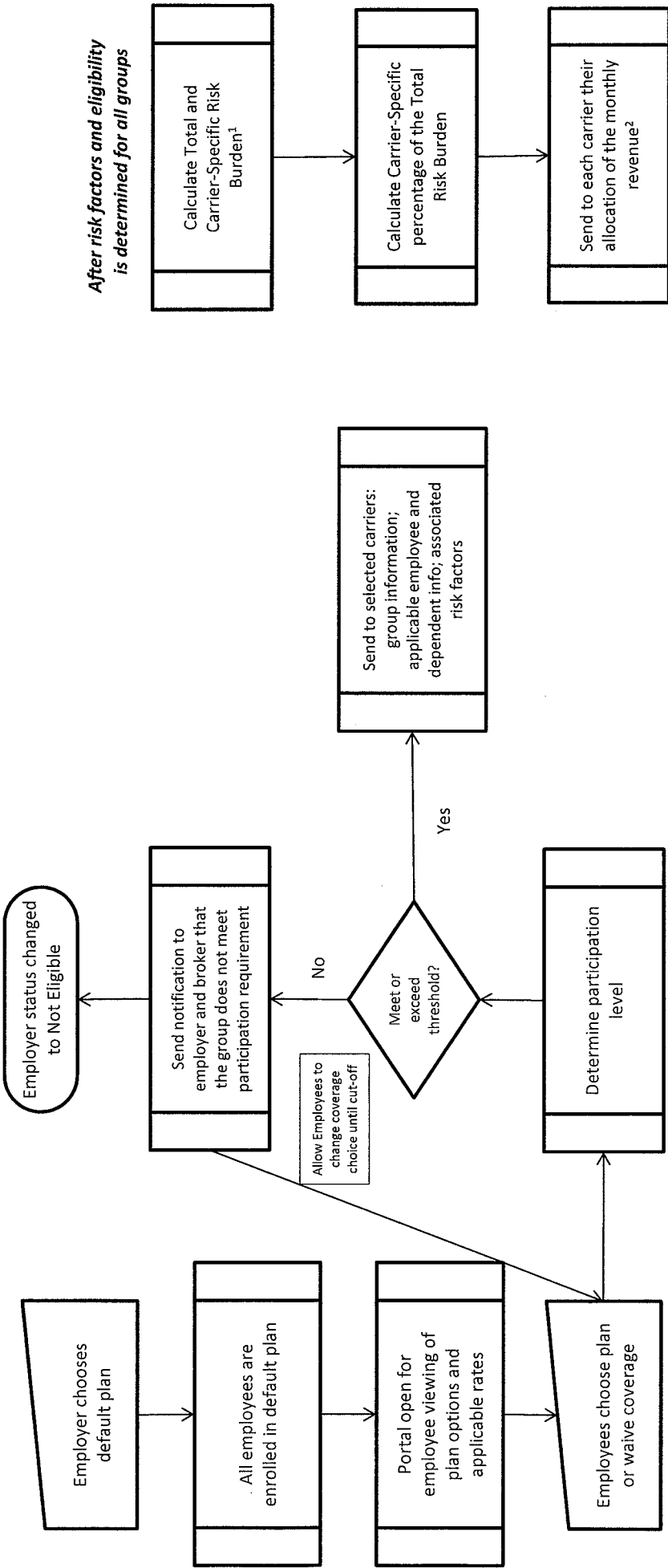


APPENDIX I

Defined Contribution Portal

Premium Allocation (Initial) Workflow

For Portal-Eligible Employers



APPENDIX I
Defined Contribution Portal
Premium Allocation (Initial) Workflow

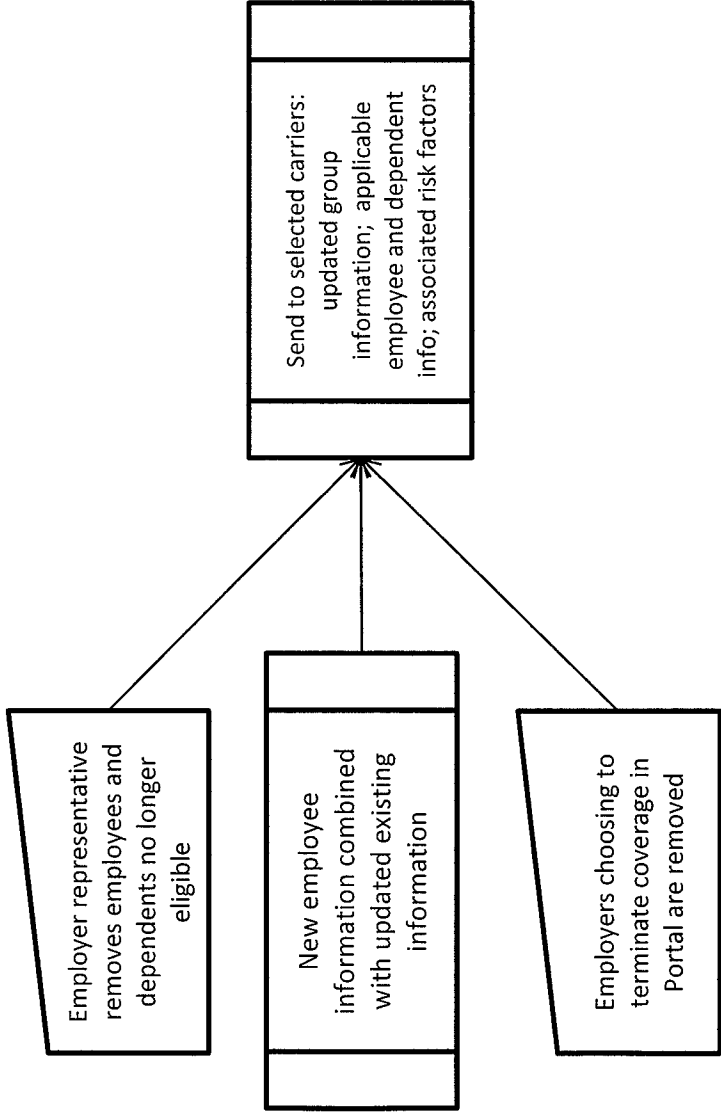
Notes:

- ¹ Risk Burden is calculated for each carrier as the sum of the product of the risk factor and premium (for the product selected) for each employee selecting one of the carrier's offered products. The Total Risk Burden is calculated as the sum of the carrier-specific Risk Burdens.
- ² Allocation of revenue equals the product of the total revenue and the carrier's percentage of the total risk burden.

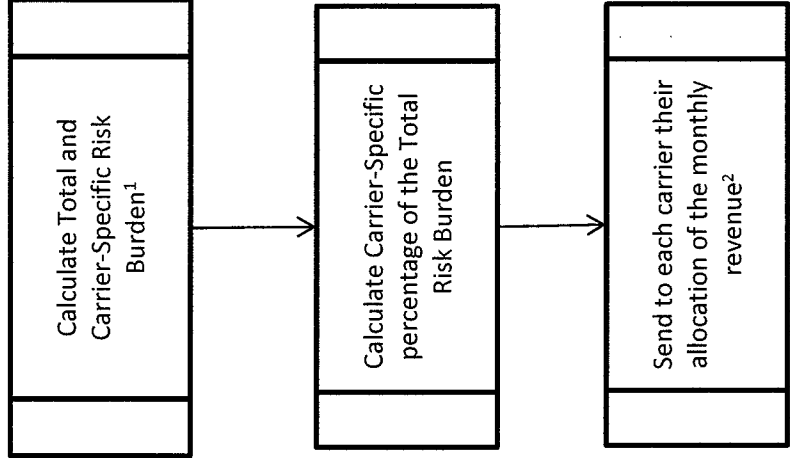
APPENDIX J

Defined Contribution Portal Premium Allocation (Monthly Update) Workflow

For Portal-Eligible Employers



After risk factors and eligibility
is updated for all groups



APPENDIX J

Defined Contribution Portal

Premium Allocation (Monthly Update) Workflow

Notes:

- ¹ Risk Burden is calculated for each carrier as the sum of the product of the risk factor and premium (for the product selected) for each employee selecting one of the carrier's offered products. The Total Risk Burden is calculated as the sum of the carrier-specific Risk Burdens.
- ² Allocation of revenue equals the product of the total revenue and the carrier's percentage of the total risk burden.

Appendix K - Anticipated Timeline for Monthly Transactions

On 1st of each month

1. Banking Vendor will receive two files from the PEA
 - a. Current Employee Eligibility File
 - b. Spending Elections File
2. Banking Vendor will receive current Risk Adjustment factors

On the 10th of each month

1. Banking Vendor will receive Employer Registration file from PEA
2. Banking Vendor will notify Employers of available invoice and that payment will be pulled from account on 15th

On 15th of each month

1. Banking Vendor will pull payments from provided electronic funds transfer information for each Employer

On 18th of each month

1. Banking Vendor will be notified by Employer banks of any electronic funds transfer failures
2. Banking Vendor will begin service recovery of electronic funds transfer failures by using provided contact information

On 28th of each month

1. Banking Vendor will distribute payments to insurers and vendors via provided bank accounts along with allocation file. Allocation file will notify insurers of any non-payments and at this time insurer will assume responsibility for payment chase during the 30-day grace period to follow

Appendix L

Utah Health Insurance Exchange Large Group Pilot Health Plan Options

09/29/10

Benefit Provisions	Plan A		Plan B		Plan C		Plan D		Plan E		Plan F	
	ACA Mandated		ACA Mandated		ACA Mandated		ACA Mandated		ACA Mandated		ACA Mandated	
Preventive Benefits												
Deductible			HDHP		HDHP		HDHP					
Employee	\$	1,000	\$	1,200	\$	2,500	\$	3,000	\$	500	\$	2,000
Employee + one	\$	2,000	\$	2,400	\$	5,000	\$	6,000	\$	1,000	\$	4,000
Employee + Family	\$	2,000	\$	2,400	\$	5,000	\$	6,000	\$	1,500	\$	4,000
Max. Deduct. per Family	2x		n/a		n/a		n/a		3x		2x	
Deductible Waiver	Yes		No		No		No		Yes		Yes	
Out of Pocket Maximum												
(includes deductible)												
Employee	\$	3,000.00	\$	3,600.00	\$	5,000.00	\$	3,000.00	\$	3,000.00	\$	4,000.00
Employee + Spouse	\$	6,000.00	\$	7,200.00	\$	10,000.00	\$	6,000.00	\$	6,000.00	\$	8,000.00
Employee + Child(ren)	\$	6,000.00	\$	7,200.00	\$	10,000.00	\$	6,000.00	\$	6,000.00	\$	8,000.00
Employee + Family	\$	6,000.00	\$	7,200.00	\$	10,000.00	\$	6,000.00	\$	6,000.00	\$	8,000.00
Lifetime Plan Maximum	None		None		None		None		None		None	
Pre-existing Limitation	TBD		TBD		TBD		TBD		TBD		TBD	
Office Visits	\$25.00		80% A.D.		80% A.D.		100% A.D.		\$25.00		\$30.00	
Inpatient Hospital	80% A.D.		80% A.D.		80% A.D.		100% A.D.		80% A.D.		80% A.D.	
Inpatient Surgery	80% A.D.		80% A.D.		80% A.D.		100% A.D.		80% A.D.		80% A.D.	
Outpatient Surgery	80% A.D.		80% A.D.		80% A.D.		100% A.D.		80% A.D.		80% A.D.	
Emergency Room	\$200 A.D.		80% A.D.		80% A.D.		100% A.D.		\$200 A.D.		\$200 A.D.	
Ambulance	80% A.D.		80% A.D.		80% A.D.		100% A.D.		80% A.D.		80% A.D.	
DME	80% A.D.		80% A.D.		80% A.D.		100% A.D.		80% A.D.		80% A.D.	
Mental Health												
Office Visits	\$25.00		80% A.D.		80% A.D.		100% A.D.		\$25.00		\$30.00	
Inpatient	80% A.D.		80% A.D.		80% A.D.		100% A.D.		80% A.D.		80% A.D.	
Prescriptions												
30 Day Supply	\$10/\$25/\$45		80% A.D.		80% A.D.		100% A.D.		\$10/\$25/\$45		\$10/\$25/\$45	
90 Day Supply	\$10/\$50/\$135		80% A.D.		80% A.D.		100% A.D.		\$10/\$50/\$135		\$10/\$50/\$135	
Rx Deductible	\$350		n/a		n/a		n/a		\$0		\$350	

*Benefits shown in bold have been identified as areas of some variance amongst the UHE carriers

Appendix M - Participation Agreement

Employer Registration

Please take note of a few things before you get started.

As a first step we suggest that you send your Human Resource manager a copy of the standard census file to be completed.

To complete this registration page you will need:

- Information on your company
- Your current health insurance plan
- Information about your producer
- Your new hire waiting period
- Copies of your latest Quarterly Wage and Tax form (requested as attachments)
- Your latest health insurance carrier bill
- Completion of the standard census file included on this registration page (requested as an attachment)

Your completed application will be sent to the carriers participating in the Exchange for determination of your group's acceptance (into the Exchange). You will be notified by the Exchange Administrator within 10 business days.

Please contact your health insurance producer or the UHE Customer Interaction Solution at 877-213-1993 with any questions. For additional information regarding the Utah Health Exchange go to: <http://exchange.utah.gov>.

Company Information

*Legal Company
Name

*Company Name
(Doing Business As)

If the same as legal name, re-

enter legal name. (Do not enter 'same'.)

Company Founded
On

(mm/dd/yyyy)

*Company Code

This is a unique code created by the employer to identify your company. The company code can be alpha/numeric and must be 5 characters long.

*Federal Tax ID

(xx-xxxxxxx)

*SIC Code

(4 digits) Find Code

*Business Type

*Address 1

Address 2

*City

*State

*Zip

*County

*Phone

(555-555-5555)

*Current Total

Number of
Employees on Payroll

*Current Total

Number of Full-time
Employees

*Total Number of
Full-time Employees
as of One Year Ago

*Number of
Employees Eligible
for Health Insurance

Current Group
Carrier (Health
Insurer)

Coverage Start Date

(mm/dd/yyyy) The first effective date with your
current carrier

Coverage End Date

(mm/dd/yyyy) This is date that your current coverage
will end.

Current Group
Carrier Policy
Number

*Requested Plan
Year Effective Date
with the Exchange

(mm/dd/yyyy)

* Fields are required

Primary User

*First Name	<input type="text"/>	
*Last Name	<input type="text"/>	
*Username	<input type="text"/>	
*Password	<input type="password"/>	Minimum of 8 characters, 1 number, and 1 capital letter.
*Confirm Password	<input type="password"/>	
*Email	<input type="text"/>	yourname@yourdomain.com
*Confirm Email	<input type="text"/>	yourname@yourdomain.com

* Fields are required

Billing Information

*Contact Name	<input type="text"/>	
*Contact Phone	<input type="text"/>	(555-555-5555)
*Address 1	<input type="text"/>	
Address 2	<input type="text"/>	
*City	<input type="text"/>	
*State	<input type="text"/>	▼
*Zip	<input type="text"/>	
*Email	<input type="text"/>	yourname@yourdomain.com
*Confirm Email	<input type="text"/>	yourname@yourdomain.com

* Fields are required

Health Insurance Broker

Please be aware that by selecting that you do not have a broker representing you, the Utah Health Exchange will provide you and your employees support when it comes to using the Exchange website. This will be available via the toll-free number at 1-877-213-1993. This support will be available for you as an employer 8am-7pm MST Monday thru Friday, and your employees will be supported 24/7 during the open enrollment period.

Do you have a broker?

☒ No ☐ Yes

Effective Date of Agent of Record

known. MM/DD/YYYY

Use today's date if not

HealthEquity Broker ID

Are you a Broker, Agent, or Agency and need a HealthEquity Broker ID?

Agent Name

License #

Agent Phone

(555-555-5555)

Agent Email

Agency Name

Do you want to participate in the 24/7 Customer Interaction Solution?

☒ No ☐ Yes

Do you have a second broker?

☒ No ☐ Yes

Effective Date of Agent of Record

known. MM/DD/YYYY

Use today's date if not

HealthEquity Broker ID

Are you a Broker, Agent, or Agency and need a HealthEquity Broker ID?

Agent Name

License #

Agent Phone

(555-555-5555)

Agent Email

Agency Name

Do you want to participate in the 24/7 Customer Interaction Solution?

☒ No ☐ Yes

Percent of Commission

0 %

Section 125 Plan

To participate in the Utah Health Exchange you will be required to offer a Section 125 Plan that allows employees to make their health plan contributions on a "pre-tax" basis. Please indicate how you will provide this plan below:

*125 Plan Option

☒ I currently offer a section 125 plan.

☐ I will purchase a section 125 plan from a third party vendor.

☐ I will purchase a section 125 plan through the Utah Health System.

* Fields are required

New Hire Waiting Period - Effective Date

What is the effective date for health insurance for new hire? You may select a different waiting period by benefit class, however please note the Administrator will charge the employer a one-time set up for each additional benefit class of \$350.

Benefit Classes

Benefit Class Name New Hire Option X Days

Benefit Class Name

New Hire Option ☐ Date Of Hire.

☐ Date of Hire Plus X days.

☐ First day of following month.

☐ First day of following month after X days.

X Days

Other Documentation

Please upload the requested files:

*Quarterly Wages & Tax File: Required of all employers. If you have employees outside of Utah, you must file a Quarterly Wages & Tax file for each state you have employees. If you are a new employer and have not filed a Quarterly Wage & Tax File yet you need to submit a copy of your current payroll here. You will also need to attach below either a copy of your Business License **OR** Articles of Incorporation (Organization)

Business License or Articles of Incorporation (Organization) File: Only required for new employers who have not filed a Quarterly Wage & Tax File yet.

*Employee Census File: Required for all employers. ([Download Standard Census Format Document](#))

*Last Insurance Bill: Required for all employers.

* Fields are required

I Agree

By clicking "I agree", the Employer is certifying that:

1. The employer will not offer a major medical health benefit plan that is not a part of the defined contribution arrangement to employees.

2. The employer will establish a mechanism for its employees to use pre-tax dollars to purchase a health benefit plan from the defined contribution arrangement market on the Internet portal, which may include:
 1. (a) a health reimbursement arrangement;
 2. (b) a Section 125 Cafeteria plan; or
 3. (c) another plan or arrangement similar to (a) or (b) which is excluded or deducted from gross income under the Internal Revenue Code.
3. The employer will inform each employee of the health benefit plan the employer has selected as the default health benefit plan for the group.
4. The employer will offer each employee a choice of any of the health benefit plans available through the Utah Health Exchange and notify the employee that the employee will be enrolled in the default health benefit plan selected by the employer and payroll deductions initiated for premium payments, unless the employee, prior to the end of the open enrollment period:
 1. (a) notifies the employer that the employee has selected a different health benefit plan available through the defined contribution arrangement in the Internet portal;
 2. (b) provides proof of coverage from another health benefit plan; or
 3. (c) specifically declines coverage in a health benefit plan.
5. The employer shall provide a notice to employees that informs them that the failure to act under item 4 is considered an affirmative election under pre-tax payroll deductions for the employer to begin payroll deductions for health benefit plan premiums.

I Agree

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